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ABSTRACT

Accountability has become a concern for public mental health programs, including the Hawaii State Mental Health Division which relies on the Multi-State Information System (MSIS) for program planning and evaluation. Accuracy in reporting and agreement in clinical judgment on the MSIS has been assumed but never tested until an analogue study was undertaken to test these assumptions. A fictitious intake interview was presented to 115 clinicians throughout the State Mental Health Division. Based on the protocol, the clinicians were asked to complete MSIS Admission Form items as well as a Global Assessment Scale rating and an item concerning treatment expectations. Inaccuracies in recording factual data as well as major disagreement in clinical judgments were found, with an error rate of 3 to 18% occurring on factual items such as marital status, education and income. On a 38-item problem checklist, there was substantial variability in the number and type of problems checked. In assessing severity of condition, the distribution of ratings on the 100-point Global Assessment Scale indicated one-third of the ratings above 60 (mild), one-third between 51 and 60 (moderate), and the remaining third in the lower half of the scale (severe). There was little agreement in anticipated treatment duration ranging from 4 to over 50 visits. Results suggest that inaccuracies in such data may have serious adverse consequences for both the clients and the mental health services. (Author)

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ACCURACY AND AGREEMENT IN CLINICAL ASSESSMENT IN A STATE MENTAL HEALTH SYSTEM

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ACCURACY AND AGREEMENT IN CLINICAL ASSESSMENT IN A STATE MENTAL HEALTH SYSTEM

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ACCOUNTABILITY HAS BECOME A MAJOR CONCERN FOR PUBLIC MENTAL HEALTH PROGRAMS. FOR PROGRAM PLANNING AND EVALUATION, THE HAWAII STATE MENTAL HEALTH DIVISION RELIES HEAVILY ON THE MULTI-STATE INFORMATION SYSTEM (MSIS) DEVELOPED BY ROCKLAND STATE HOSPITAL RESEARCH CENTER IN NEW YORK. FOR THE PAST TEN YEARS EACH NEWLY ADMITTED PATIENT HAS BEEN CLASSIFIED ON A NUMBER OF DEMOGRAPHIC AND CLINICAL DIMENSIONS ON THE MSIS ADMISSION FORM. IN GENERAL, THE DEMOGRAPHIC DATA (E.G., AGE, SEX, INCOME) RECORDED ON THE ADMISSION FORM APPEAR TO BE FACTUAL, OBJECTIVE INFORMATION. THE CLINICAL DATA (E.G., PROBLEM APPRAISAL, SEVERITY, AND DIAGNOSIS) INVOLVE MORE SUBJECTIVITY AND JUDGEMENT. EXPANSION OF THE MSIS TO INCLUDE OUTCOME MEASUREMENT IS UNDER CONSIDERATION. ACCURACY IN REPORTING AND AGREEMENT IN CLINICAL JUDGEMENT ON THE MSIS HAVE BEEN ASSUMED BUT NEVER TESTED. AN ANALOGUE STUDY WAS UNDERTAKEN TO TEST THESE ASSUMPTIONS.

METHOD

A FICTITIOUS INTAKE INTERVIEW SUMMARY WAS PRESENTED TO 115 MENTAL HEALTH PROFESSIONALS AT MEETINGS THROUGHOUT THE STATE MENTAL HEALTH DIVISION. BY PROFESSION, 19 PERCENT WERE PSYCHIATRISTS, 23 PERCENT WERE PSYCHOLOGISTS, 36 PERCENT WERE SOCIAL WORKERS, AND 23 PERCENT WERE REGISTERED NURSES. THIS SAMPLE COMPRISED A MAJORITY OF PROFESSIONAL OUTPATIENT STAFF. THE FICTITIOUS INTAKE INTERVIEW SUMMARY (SEE HANDOUT) CONTAINED INFORMATION ABOUT PRESENTING

COMPLAINTS, PRECIPITATING FACTORS, SOCIAL HISTORY, DEMOGRAPHIC DATA, AND INTERVIEWER'S OBERVATIONS. BASED ON THE PROTOCOL, THE CLINICIANS WERE ASKED TO COMPLETE SELECTED MSIS ADMISSION FORM ITEMS. THEY WERE THEN ASKED TO PROVIDE AN ESTIMATE OF NUMBER OF VISITS ANTICIPATED FOR THE FICTITIOUS CLIENT. SPITZER, GIBBON, AND ENDICOTT'S GLOBAL ASSESSMENT SCALE WAS ALSO COMPLETED TO PROVIDE AN ASSESSMENT OF DEGREE OF IMPAIRMENT. INTERCLINICIAN AGREEMENT IN COMPLETING THE FORMS WAS ASSESSED BY PRINTING OUT FREQUENCY DISTRIBUTIONS OF EACH ITEM KEY PUNCHED.

RESULTS

SUBSTANTIAL INACCURACIES IN RECORDING FACTUAL DATA WERE FOUND. THE FICTITIOUS CLIENT WAS DESCRIBED AS "HAVING A B.A." AND "MAKING $1,000 MONTH WITH WHICH HE SUPPORTED HIMSELF AND HIS 8 YEAR OLD SON." WITH REGARD TO EDUCATION 6 PERCENT OF THE CLINICIANS RESPONDING WERE IN ERROR. WITH REGARD TO NUMBER OF INDIVIDUALS ON FAMILY INCOME 3 PERCENT WERE INACCURATE. WITH REGARD TO INCOME 18 PERCENT OF THE CLINICIANS RESPONDING INDICATED THAT THE CLIENT HAD A WEEKLY NET FAMILY INCOME OF $300 AND OVER.

THE LEVEL OF INACCURACY FOR THESE THREE ITEMS, RANGING FROM 3 TO 18 PERCENT, MAY REDUCE THEIR UTILITY AS A BASIS FOR DEMOGRAPHY OR ACCOUNTABILITY. OF PARTICULAR INTEREST IS THE FACT THAT CLIENT INCOME AND NUMBER OF PEOPLE ON IT ARE THE BASIS FOR MAKING BILLING DECISIONS. A GREAT DEAL OF TIME, ENERGY, AND MONEY HAS BEEN SPENT ON DEVELOPING A FEE SCHEDULE AND RECOUPMENT METHODS. CLEARLY THESE MUST HAVE AS THEIR BASIS AN ACCURATE ACCOUNT OF CLIENT INCOME.

MAJOR DISAGREEMENTS IN CLINICAL JUDGEMENT WERE FOUND. STAFF WERE ASKED WHETHER THE CLIENT PROTOCOL CONSTITUTED AN EMERGENCY. OF THE STAFF RESPONDING, 22 PERCENT SAID YES; 78 PERCENT SAID NO.

ON THE 38 ITEM MSIS PROBLEM CHECKLIST, THERE WAS SUBSTANTIAL VARIABILITY IN THE NUMBER AND TYPE OF PROBLEMS CHECKED. OF THE 38 ITEMS, FOUR SYMPTOMS (I.E., SLEEP PROBLEMS, JOB PROBLEMS, SUICIDAL THOUGHTS, AND DEPRESSED MOOD) WERE IDENTIFIED BY 93 PERCENT OR MORE OF CLINICIANS. TWO OTHER PROBLEMS (I.E., EATING PROBLEMS, AND PROBLEMS WITH OTHER PEOPLE) WERE CHECKED BY A MAJORITY OF RESPONDENTS. HOWEVER, 19 OTHER PROBLEMS WERE CHECKED AT LEAST ONCE WITH 11 OF THEM CHECKED BY LESS THAN 10 PERCENT OF CLINICIANS. IN OTHER WORDS, THERE WAS SUBSTANTIAL AGREEMENT IN IDENTIFYING FOUR PROBLEMS; HOWEVER, A BROAD RANGE OF OTHER PROBLEMS WERE INCLUDED WITH LITTLE CONSENSUS ON THESE ITEMS OVERALL.

A DSM II DIAGNOSTIC IMPRESSION HAS BEEN REQUIRED ON THE MSIS ADMISSION FORM. FOR THE FICTITIOUS CLIENT, 82 PERCENT OF DIAGNOSES SPECIFIED EITHER NEUROTIC DEPRESSION OR ADJUSTMENT REACTION. AMONG THE REMAINING 18 PERCENT OF CLINICIANS WHO GAVE A DIAGNOSTIC IMPRESSION, THE DIAGNOSES INCLUDED PSYCHOSES (4%), OTHER NEUROSES (5%), INADEQUATE PERSONALITY (3%), OTHER ADJUSTMENT REACTION (2%), AND SOCIAL MALADJUSTMENT (4%).

THE GLOBAL ASSESSMENT SCALE WAS USED AS A MEASURE OF CLINICIAN'S PERCEPTION OF SEVERITY OF CONDITION. THE SCALE REQUIRES THE CLINICIAN TO RATE A CLIENT ALONG A 100 POINT CONTINUUM OF MENTAL HEALTH RANGING FROM SUPERIOR FUNCTIONING AT THE HIGH END TO THE NEED FOR INTENSIVE CARE AND CONSTANT SUPERVISION AT THE LOW END. THE MEAN SCORE FOR THIS CLIENT WAS 53. CLINICIANS' RATINGS RANGED FROM

5 TO 88 WITH 40% OF CLINICIANS RATING THE CLIENT SERIOUSLY IMPAIRED, 34% MODERATELY DISTURBED, AND 26% WITH MILD SYMPTOMS.

CLINICIANS WERE ALSO ASKED HOW MANY VISITS THEY ANTICIPATED THIS FICTITIOUS PATIENT BEING SEEN FOR. THE MEAN NUMBER OF VISITS FOR THE GROUP WAS 13 WITH A RANGE FROM 4 TO MORE THAN 50. OF PARTICULAR INTEREST ASIDE FROM THIS CONSIDERABLE VARIATION IS THE FACT THAT THE AVERAGE LENGTH OF STAY FOR OUTPATIENT CLIENTS ACTUALLY SEEN IN THE HAWAII MENTAL HEALTH DIVISION IS 4 VISITS. THERAPIST EXPECTATIONS OF LENGTH OF STAY MAY REFLECT MORE OF WHAT THE THERAPIST BELIEVES WOULD BE NECESSARY TO ACCOMPLISH CHANGE THEN ACTUAL EXPERIENCE WITH CLIENTS.

DISCUSSION

BEFORE DISCUSSING THE IMPLICATIONS OF THESE RESULTS, WE WOULD LIKE TO POINT OUT THAT IT SEEMS LIKELY THAT THE MAGNITUDE OF ERROR AND DISAGREEMENT FOUND IN THIS STUDY UNDERSTATES THE LEVEL OF INACCURACY IN THE ACTUAL MSIS DATA BANK. THERE ARE SEVERAL REASONS FOR THIS BELIEF. FIRST, UNLIKE AN ACTUAL INTERVIEW WHICH IS SUBJECT TO VARIATION IN CLINICIANS' DATA COLLECTION AND RECALL ABILITY, THE CLIENT INFORMATION IN THE CURRENT STUDY WAS PRESENTED IN A CONSTANT WRITTEN FORMAT WHICH COULD BE REFERRED TO WHILE FILLING OUT THE FORM. SECOND, THE CURRENT PRESENTATION WAS LIMITED TO RESPONSES OF PROFESSIONAL STAFF, AND THERE IS SOME REASON TO SUSPECT THAT PARAPROFESSIONALS, SOME OF WHOM AT TIMES DO CONTRIBUTE TO THE MSIS DATA SYSTEM, MAY BE MORE INACCURATE IN RECORDING. FOR EXAMPLE, 46 PARAPROFESSIONALS DID PARTICIPATE IN THIS STUDY, AND THEY WERE FOUND TO MAKE SUBSTANTIALLY MORE ERRORS THAN PROFESSIONALS

IN COMPLETING THIS FORM. THESE DATA WERE EXCLUDED FROM THE ANALYSIS, HOWEVER, BECAUSE PARA-PROFESSIONAL/TRAINING AND EXPERIENCE IN USE OF THE FORM APPEARS TO BE QUITE VARIABLE. THIRDLY, WHEREAS THE STUDY DATA WERE KEY-PUNCHED AND VERIFIED, IN ACTUAL PRACTICE, THE MSIS ADMISSION FORM DATA ARE READ BY AN OPTICAL SCANNING DEVICE WHICH MAY AMPLIFY ERROR DUE TO INATTENTION TO DETAIL, E.G., INCOMPLETE ERASURES, STRAY MARKS, ETC.

THE RESULTS OF THIS STUDY HAVE A NUMBER OF IMPLICATIONS FOR MENTAL HEALTH PROGRAMS.

FIRST, THE RELIABILITY OF INFORMATION ENTERED INTO A DATA SYSTEM, SUCH AS THE MSIS SYSTEM, SHOULD NOT BE ASSUMED. THERE IS A NEED FOR DETERMINING THE ACCURACY OF RELATIVELY CLEARCUT DEMOGRAPHIC DATA, SUCH AS FAMILY INCOME, AS WELL AS AGREEMENT IN MORE SUBJECTIVE AREAS OF CLINICAL JUDGEMENT.

SECOND, INACCURACY IN SUCH DATA MAY HAVE SERIOUS ADVERSE CONSEQUENCES. UNRELIABLE RECORDING OF DEMOGRAPHIC DATA, FOR EXAMPLE, MAY RESULT IN DRAWING ERRONEOUS CONCLUSIONS REGARDING MENTAL HEALTH SERVICE UTILIZATION BY TARGET GROUPS AND IN MISDIRECTED PROGRAM PLANS. DIAGNOSTIC VARIABILITY REDUCES ANY ADVANTAGES AND INCREASES HAZARDS ASSOCIATED WITH CLASSIFYING MENTAL HEALTH CLIENTS.

THIRD, LACK OF AGREEMENT IN CLIENT ASSESSMENT MEETS HEAD ON WITH INCREASING DEMAND FOR ACCOUNTABILITY STUDIES. THE DETERMINATION OF CLIENT RESPONSE TO TREATMENT DEPENDS ON RELIABLE ASSESSMENT OF CLIENT STATUS BOTH PRIOR TO AND FOLLOWING THERAPY. THIS ISSUE IS NOT UNIQUE TO HAWAII; A RECENT NIMH COMMITTEE REPORT HAS CONCLUDED THAT THE TECHNOLOGY FOR ACCURATELY MEASURING CLIENT OUTCOME IS NOT YET IN EXISTENCE. THUS, THERE IS A NEED FOR EXERCISING CAUTION IN INTERPRETATION OF CURRENT OUTCOME MEASUREMENT DATA AS WELL AS A

NEED FOR FURTHER RESEARCH ON MEASUREMENT TECHNIQUES.

FOURTH, ALTHOUGH CURRENT MEASUREMENT TOOLS ARE FAR FROM PERFECT, ATTEMPTS SHOULD BE MADE TO REDUCE INACCURACY OF RECORDING. IN THE CASE OF DEMOGRAPHIC DATA, GREATER ACCURACY AS WELL AS EFFICIENCY MIGHT BE EXPECTED TO RESULT FROM COMPLETION OF FORMS

BY THE INDIVIDUAL CLIENT RATHER THAN BY THE CLINICIAN WHOSE CONCERN TENDS TO BE FOCUSED ON CLINICAL PROBLEMS RATHER THAN ON ROUTINE DATA COLLECTION. VARIABILITY IN CLINICAL JUDGEMENT MAY INDICATE A NEED FOR INCREASED TRAINING, SUPERVISION, OR COLLABORATION AMONG CLINICIANS IN CLIENT ASSESSMENT. ADDITIONALLY, VARIABILITY MAY HAVE BEEN INCREASED BY CLINICIAN FRUSTRATION IN DEALING WITH AN OUTMODED AND CLUMSY DATA SYSTEM DEVELOPED FOR A HOSPITAL IN THE EARLY SIXTIES. THIS POINTS TO A NEED FOR A MORE RESPONSIVE AND FLEXIBLE ON-LINE DATA PROCESSING SYSTEM.

FINALLY, THE DIVERSITY OF PSYCHOTHERAPEUTIC THEORY AND METHOD MAKES A DEGREE OF VARIABILITY IN CLINICAL JUDGEMENT AND TREATMENT PLANNING INEVITABLE AND EVEN DESIRABLE. ADHERENCE TO A SINGLE ARBITRARY STANDARD OF CLIENT ASSESSMENT AND CARE UNDER PRESENT CIRCUMSTANCES WOULD BE LIKELY TO INTERFERE WITH EFFECTIVE SERVICE DELIVERY BY A MULTIDISCIPLINARY AND THEORETICALLY DIVERSE PROFESSIONAL STAFF. ON THE OTHER HAND, LACK OF CONSENSUS IN CLINICAL JUDGEMENT ACCENTUATES THE NEED FOR CLEAR COMMUNICATION AND DOCUMENTATION OF THE CLINICIANS' EXPECTATIONS AND RATIONALES UNDERLYING THEIR VARYING APPROACHES.

Mike Jones, a 39 year old, Caucasian man was referred to your program for services. He is currently living with his son. A friend suggested that he seek help. The friend noticed that he had been acting "nervous" for the last month ever since he broke up with a female companion. Never having received professional help for emotional problems before he at first resisted coming in for help. He stated, "I'm not the type of individual who feels comfortable exposing myself to other people." Two days ago, however, he found himself imagining how peaceful it would be to swallow a bottle of sleeping pills and "end it all." This thought frightened him and he decided to call for an appointment.

During the course of the interview he presented himself as a well educated, shy, inhibited, introspective individual. He reported having a B.A. and that he worked as an office manager in a big department store. He was married for 10 years and got a divorce three years ago. He had been seeing a female companion for six months and had hopes of remarrying. She then terminated the relationship unexpectedly about one month ago.

Since that time he had been staying awake until very late at night and consequently his job efficiency was starting to suffer. He reported acting irritably toward co-workers. Moreover, he found himself having "crying spells" in which he would start crying "for no apparent reason." "The worse part of this whole thing is that I don't understand why she left me," he said.

He had been making $1,000/month with which he supported himself and his eight year old son. He was afraid that if he didn't pull himself together soon he would be fired. He had lost five pounds over the last month. He also stated that his son had been having difficulties in school. He had been diagnosed as "hyperactive" by a school counselor and the patient felt at a loss as to how to help him.

He reported that he was born and spent most of his life in Hawaii. He was raised by strict parents who were not afraid to hit him if he were "bad." His mother was said to be domineering. His father who died 5 years ago "drank all the time" and was "unpredictable." While he got good grades in school he reported having difficulty relating to other students. He had a few close friends but he said, "I spent a lot of time alone, reading or thinking." He defined himself as introverted. He married a woman he didn't like because it seemed like a good idea at the time." They spent much of their married time arguing and he said that "the more we lived together the less we had in common." She drank and accused him of being "lousy in bed." He stated that she criticized him constantly. After leaving her he felt lonely and doubted that he would ever love another woman again.

During the interview he cried frequently and said, "I need help very much, but I don't think anyone can really give it to me. I've never felt this way before. The one thing I keep thinking over and over is 'what is wrong with me?'"